VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Quality Assessment and Performance Improvement (QAPI)

FY 2023-2024 Work Plan Evaluation

A Living Document

Updated September 2024

Table of Contents

Structure and Elements

The Ventura County Behavioral Health (VCBH) Quality Program is focused on the successful implementation of the mission, goals, and commitment of the Behavioral Health Department. To learn more about VCBH, please follow this link: Home - Ventura County Behavioral Health (vchca.org)

The purpose of the annual Quality Assessment and Performance Improvement (QAPI) Work Plan is to provide a working document for the monitoring, implementation, and documentation of efforts to improve both mental health and substance use service delivery. The document provides an evaluation of progress made on the FY 2023-24 QAPI Work Plan initiatives and goals. Some of the initiatives and goals are being carried forward into the FY 2024-25 QAPI Work Plan, and others are new based on identified areas for monitoring and improvement.

Quality Improvement is defined as a systematic approach to assessing services and improving them. VCBH's approach to quality improvement is guided by certain principles, including data driven decision-making and employee and leadership involvement, as effective quality improvement initiatives involve people at all levels of the organization to improve quality (and delivery) of services.

Quality Management (QM) Program

In FY 2023-24, the Quality Management program began to evolve and grow to ensure all CalAIM, BH Administrative Integration, Managed Care Operations, and other DCHS-mandates requirements are met. More information is provided in the FY 2024-25 QAPI Work Plan.

Quality Improvement Committee (QIC)

The Ventura County Behavioral Health (VCBH) QIC is an overarching decision-making body which helps to facilitate discussions and enables systematic monitoring of issues of importance to the department. The QIC is comprised of seven subcommittees with distinct focus areas. The ratified QIC Charter is available with this document as reference. **To maintain continuous quality improvement efforts, key performance indicator outcomes and results will be presented to the QIC regularly to facilitate discussion and implement performance improvement methods if/when needed when falling short of outlined goals.**

QAPI FY2023-2024 Annual Evaluation

The impact and effectiveness of the QAPI program is evaluated annually through an Annual Reporting/Work Plan evaluation process. This process helps to prioritize areas for improvement over the upcoming fiscal year. An evaluation of the effectiveness of quality assessment and performance improvement activities is completed at the conclusion of each fiscal year and is reviewed with stakeholders (e.g., QIC). The evaluation summarizes progress associated with each of the QAPI Work Plan goals and objectives, and includes actions taken in response to outcomes. Based upon the evaluation, revisions may be made to subsequent QAPI Work Plans, allowing for issues and progress can be tracked over time.

At the completion of the fiscal year, the Quality Improvement Committee (QIC) reviews the department's effectiveness at achieving the goals and objectives outlined in the QAPI Work Plan. Using a report template titled 'Annual Report' each responsible party gathers and analyzes data, assesses performance, reviews effectiveness of actions and identifies future steps. Each Work Plan goal is rated as "Met" "Partially Met" (for in progress goals) or "Not Met."

The Quality Improvement Committee (QIC) and subcommittees review and discuss the QAPI and uses the information to establish the Work Plan goals for the following fiscal year. The following pages present the results of the FY2023-2024 QAPI evaluation of goals and objectives.

Initiative 1. Timely and Efficient Client Access to Services

Goal # 1.1 – No Wrong Door (QM/Managers)

1. Objectives:
    a. Workflows and processes for client intake with the transition to the new EHR will be solidified by the end of the fiscal year
    b. At least 80% of clients requesting a service will be connected to the right level of care via the screening or transition of care tool [for MH services]
    c. Process of providing loop closure for referrals from MCPs will be solidified by the end of the fiscal year (June 30th, 2024)

2. FY 2023-2024 Overall Goal was: ☐ MET ☒ Partially MET ☐ Not MET

    Notes/Comments: Objectives a and c were met. For objective b there is ongoing work and collaboration with Gold Coast/Carelon/Kaiser and methods of data exchange have been established and are now predominantly solidified. Objective b will be kept for FY24-25 as we make progress on the data exchange efforts to be able to adequately calculate these rates. Additionally, as part of ongoing work, we are still refining some workflows (e.g., Inquiry screen field options for the Access & Outreach team to make reporting easier) but all necessary work pertaining to clients' request for services will be solidified within the FY24-25 fiscal year.

3. Quality Improvement Activities/Actions Taken Over the Past Year:
    - Care Management and QI team members held regular meetings with the MCP (Gold Coast) and established collaborative workgroups to refine the process of providing loop closure information for referrals from MCPs
    - QI team met with Access & Outreach (A&O) to help support the refinement of their workflows and add additional field options for optimal data reporting

4. Summary of Results and Next Steps

    - Continued collaboration with MCP partners in FY24-25
    - Solidify additional key workflows for tracking and monitoring level of care [assessing the feasibility of modifying the ToC tool to accommodate additional data fields and elements of interest (i.e., dates)] for ease of monitoring client level care

5. Plan for Current Goal

☐ Keep the goal with no change for the upcoming year

☒ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments: the overall goal will remain, but the objectives will be modified to fulfill the needs of the agency (please see FY 24-25 QAPI work plan) – in particular, objective b will be carried over to the FY24-25 work plan for continued monitoring

☐ Completed - retiring the goal

Goal # 1.2 – Maintain Timeliness Standards (QI; SUS; A&O)

1. Objectives:
    a. At least 85% of routine (non-urgent) initial requests will be offered an assessment (or first appointment) within 10 business days of the initial request (Baseline FY22-23 MHP average=84% among all beneficiaries; Baseline FY22-23 SUS = 89%) (See Tables 1 & 2 for timeliness standards for FY23-24)
    b. At least 70% of urgent requests will receive an assessment within 48 hours of initial request (Baseline FY22-23 MHP average= 67% among all beneficiaries; FY22-23 SUS = 53%) (See Tables 1 & 2 for timeliness standards for FY23-24)
    c. At least 90% of (MHP)/15% of (SUS) clients will receive a follow-up appointment within 7 days after inpatient treatment (Baseline FY22-23 MHP average= 90% among all beneficiaries; Baseline FY22-23 SUS post-residential treatment = 12%) (See Tables 1 & 2 for timeliness standards for FY23-24)
    d. At least 85% of beneficiaries experiencing a MH crisis will receive a crisis intervention/evaluation within 60 minutes of the request.

2. FY 2023-2024 Overall Goal was: ☐ MET ☒ Partially MET ☐ Not MET
   Notes/Comments: We did not fully meet all objective standards due to changes in the EHR and the way data are coded and collected. These objectives and standards will be carried over for FY24-25 QAPI work plan. Moreover, for Objective d, we are still in the process of collaborating with clinical and operational leads to refine the methodology, in Table 1 we present preliminary estimates of percent beneficiaries that had a crisis intervention within 60 minutes of the request.

3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - Staff workgroups were conducted to document each division's workflow to capture timeliness data.
    - Trainings were provided to each division on the new Timeliness screens in SmartCare.
    - Weekly timeliness error reports were sent out to clinics.
    - An EHR widget was created to flag staff to complete timeliness screens.

4. Summary of Results and Next Steps

Table 1 - Mental Health: FY23-24 Timeliness Standards and Rates

Metric	DHCS Standard	All Services	Adult Services	Youth Services
1. Initial request to first offered **routine** appointment	10 BD	85%	93%	76%
2. Initial request to first **rendered** service	10 BD	80%	87%	71%
3. Time to First Offered Non-Urgent Psychiatry Appointment	15 BD	100%	100%	100%
4. Time to First Rendered Psychiatry Service	15 BD	100%	100%	100%
5. Service request for urgent appointment to actual face to face encounter	48 hours	68%	68%	0%*
6. Follow-up services after psychiatric hospitalization	7 CD	56%	50%	81%
7. Beneficiaries experiencing a MH crisis will receive a crisis intervention/evaluation	60 minutes	97%	99%	94%

Note. BD= business days; CD= calendar days; * = out of 3 clients and thus not reported due to inconsistencies in the data

Table 2 - Substance Use Services: FY23-24 Timeliness Standards and Rates

Metric	DHCS Standard	All Services	Adult Services	Youth Services
1. Initial request to first offered routine appointment	10 BD	94%	94%	81%
2. Initial request to first rendered routine service	10 BD	85%	85%	61%
3. Initial routine MAT request to NTP appointment/contact	3 BD	80%	80%	N/A
4. Initial request for urgent appointment to actual face to face encounter	48 hours	72%	74%	58%
5. Follow-up services post-residential discharge	7 CD	18%	19%	0%*

Note. BD= business days; CD=Calendar days; * = out of 10 clients

- Results are summarized in Tables 1 and 2
- Next steps include continued work on streamlining workflows for more efficiency in calculating these standards
- Continued collaboration with key stakeholders (Operations leads) to maintain timeliness standards

4. Plan for Current Goal

☒ Keep the goal with no change for the upcoming year

☐ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments:

☐ Completed - retiring the goal

Goal # 1.3 – 24/7 Access/Referral Line (QI; A&O; SUS)

1. Objectives:
    a. At least 90% of Access Line calls will be answered within 30 seconds (both MHP & SUS)
    b. Less than 15% of Access Line calls will be dropped or abandoned (baseline for MHP FY22-23 = 12.7% of calls abandoned during business hours; SUS = 25% overall from May to October 2023)
    c. 100% of after-hours calls (5 pm to 8 am) will be answered and appropriately responded to by VCBH's crisis team
    d. Average call durations will be re-assessed for the Access Line given the administration of DHCS's screening tool (Baseline for FY22-23 MHP duration of calls = 3:47 seconds during business hours; SUS = 19m:31s due to the completion of a full RFS assessment)

2. FY 2023-2024 Overall Goal was: ☐ MET ☒ Partially MET ☐ Not MET
   Notes/Comments:

3. Quality Improvement Activities/Actions Taken Over the Past Year:
    - Multiple meetings were held with the A&O team to discuss workflows
    - Numerous meetings were held with County IT staff to learn the Cisco software system (for logging all calls to the referral line)
    - In collaboration with A&O, the QI team developed a report to be provided to A&O regularly for review of access line calls

4. Summary of Results and Next Steps

    - In collaboration with A&O, the QI team developed a report to be provided to A&O regularly for review of access line calls
    - QI also established regular meetings with A&O staff to discuss report findings
    - Although objective c was met, due to the fact that the VCBH crisis team responds to all calls after hours, we will be removing this objective and replacing it with a more relevant metric of interest
    - In FY22-23, the lengthy call durations for SUS posed an issue as calls were taking over 15 to 20 minutes to complete. This is no longer an issue as our workflows and processes have been modified (average SUS call duration = 12m:42 seconds in FY23-24; average MH call duration = 9m:38 seconds. We will be removing this objective and replacing it with a more relevant metric for FY24-25

5. Plan for Current Goal

☐ Keep the goal with no change for the upcoming year

☒ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments: Objectives c and d will be removed and replaced with other objectives that more directly align with VCBH's goals and key performance metrics (see QAPI FY24-25 work plan)

☐ Completed - retiring the goal

Initiative 2. Continuous Quality Improvement of Operations

Goal # 2.1 – Detection of Over and Under Utilization of Services (QM/UR)

1. Objectives:
    a. Review at least a 5% sample of persons in care who had at least one billable service in the previous month to identify over- or under-utilization of services
    b. Develop processes within the new EHR to increase accessibility of data which includes ability to view billed services from our CBOs, availability of reports to aide in review in SmartCare and transition of compliance reviews into the CalMHSA Audit Tools by 6/30/2024.
    c. Quarterly review of VCBH programs/clinics to ensure all programs are providing appropriate levels of services. Exception: 5% of all DUI charts are reviewed every 6 months

2. FY 2023-2024 Overall Goal was: ☐ MET ☒ Partially MET ☐ Not MET

    Notes/Comments:

3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - Routine Care Plan audits are conducted to ensure that the services provided are necessary and align with the client's clinical needs as outlined in the plan.
    - Standardized audit tools are used to evaluate the appropriateness of services rendered.
    - Regularly educate and guide providers to understand the criteria for service provision and appropriate utilization of services.

4. Summary of Results and Next Steps

    - Enhanced compliance with Care Plan requirements.
    - Increased awareness and understanding of appropriate service utilization and Care Plan requirements.
    - The continuous monitoring system will be improved to regularly assess service utilization patterns and care plan adherence.

5. Plan for Current Goal

☐ Keep the goal with no change for the upcoming year

☒ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments:

☐ Completed - retiring the goal

Goal # 2.2 – Maintaining Provider Credentialing (QM)

1. Objectives:
    a. 100% of all providers will maintain valid and current credentials, as indicated by monthly licensing report (QM)
    b. Ensure that provider lists provided to the general public/consumers are accurate and up to date on VCBH's website with an accuracy rate of at least 95%
    c. 100% of all contractors will maintain valid and current credentials (Contracts)

2. FY 2023-2024 Overall Goal was: ☒ MET ☐ Partially MET ☐ Not MET
   Notes/Comments:
   a. According to the Sanction Check report as well as notifications for Licenses Expiring Report, all providers maintained valid and current credentials during FY 23-24.

3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - We are in the process of enrolling all licensed providers who qualify for Medicare
    - To prepare for the Medicare enrollment process we updated, verified, and validated all provider information
    - Updates to VCBH's website is currently underway. Additionally, the process of collecting and maintaining provider information is being updated and refined. Once finalized, an updated provider directory will be made available on VCBH's website.
    - In general, all contractors have to maintain valid and current credentials

4. Summary of Results and Next Steps

    - Provider information has been shared throughout VCBH administration and care management and we are looking to develop more cohesive systems to track our providers
    - We are looking to possibly utilize a software system called MD Staff which will enable providers to add and update their credentialing information and VCBH staff to validate it. This system will also run monthly sanction checks to comply with DHCS standards.

5. Plan for Current Goal

☒ Keep the goal with no change for the upcoming year

☐ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments:

☐ Completed - retiring the goal

Goal # 2.3 – Increase Staff Participation in Department-wide Decision-making (QI/QM)

1. Objectives:
    a. Involve/add at least 5 new VCBH staff to quality and operational discussions pertaining to the QAPI, VCBH key performance indicators, cultural competency plan.
    b. Include discussion of the overall QAPI and its objectives as a standing agenda item in QIC Quality Committee meetings (during summer & fall sessions)
    c. Report outcomes/findings to the QIC and discuss and implement performance improvement methods if/when needed when falling short of these goals for purposes of continuous quality improvement

2. FY 2023-2024 Overall Goal was: ☒ MET ☐ Partially MET ☐ Not MET

    Notes/Comments: These objectives were all met. VCBH has increased staff participation by establishing QIC subcommittees where various staff become members and have voting and decision-making, privileges.

3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - QIC and QIC subcommittees successfully met multiple time during the past fiscal year and discussed a variety of topics pertaining to department quality improvement efforts
    - Topic elevation templates and reports were presented to the QIC committee for discussion and voting as needed
    - The Quality Oversight Committee identified gaps related to the discussion of the QAPI throughout the year
    - The Information Architecture Committee highlighted issues with communications between clients and clinic staff via texting
    - The Staff Experience Subcommittee elevated ideas to help staff share and discuss the results from Employee Engagement surveys
    - The Community Experience Subcommittee discussed the EQRO recommendation to improve internal and external stakeholder engagement

4. Summary of Results and Next Steps
    - Division and area leads agreed to hold space in team meetings to discuss/evaluate the QAPI and quality improvement goals
    - As a direct result of the Information Architecture Committee's work, the department is in the process of implementing a secure texting platform

- Division and area leads agreed to a set schedule to review, sign, and share the results of the Employee Engagement Survey
- Leads from the Community Experience Subcommittee worked with Quality Improvement to implement a system to bolster stakeholder engagement efforts

5. Plan for Current Goal

☐ Keep the goal with no change for the upcoming year

☒ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments:

☐ Completed - retiring the goal

Initiative 3. Enhance Data-Driven Decision Making

Goal # 3.1 – Establish Agency-wide Key Performance Indicators (QI/VCBH Leads)

1. Objectives:
    a. Leadership team will reach consensus on agency-wide KPIs by end of the fiscal year (FY23-24); outlined KPIs will then be approved by the Executive Team and incorporated into the Strategic Plan by the start of the next FY
    b. Once consensus is reached, provide regular reporting (e.g., quarterly, biannually, annually) of established indicators to Executive Leadership, including Director of HCA

2. FY 2023-2024 Overall Goal was: ☐ MET ☒ Partially MET ☐ Not MET

    Notes/Comments: These objectives are still in progress and this goal area will be carried over to the FY24-25 work plan

3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - Progress was made to develop agency-wide KPIs and presented to the QIC members but there was no finalization of area KPIs or metrics. This endeavor was presented as a two-phase project: Phase 1 – solidifying the KPIs; Phase 2-establishing regular reporting
    - Ongoing conversations will be held to refine KPIs and area metric so that reporting will be standardized

4. Summary of Results and Next Steps

    - Continue to collaborate with key stakeholders (Operational leads) to develop key performance metrics for Access, Timeliness, Quality, Outcomes, and Managed Care Operations, and Fiscal/Billing
    - Develop quarterly reports on an ongoing basis for key stakeholders

5. Plan for Current Goal

☒ Keep the goal with no change for the upcoming year

☐ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments:

☐ Completed - retiring the goal

Goal # 3.2 – Enhancing Cultural Competency & Linguistics at VCBH (OHECD/Training)

1. Objectives:
    a. At least 85% of existing staff will complete their annual cultural competency training as assessed by attestations and training completions from VCBH's learning management system (i.e., Vector Solutions for mandatory trainings)
    b. Implementation of the newly updated Cultural Competency template by the Office of Health Equity and Cultural Diversity

2. FY 2023-2024 Overall Goal was: ☐ MET ☐ Partially MET ☒ Not MET
   Notes/Comments:
   a. 82% of existing staff completed their annual cultural competency training as assessed by attestations and training completions from VCBH's learning management system.
   b. DCHS has not released a new CCP template for counties. DHCS has stated for counties to use the 2010 CCP template until further notice. VCBH continues to monitor DHCS updates and BHINs.

3. Quality Improvement Activities/Actions Taken Over the Past Year:
    - Development of operational guidelines to inform staff of how to access and utilize VCBH contracted language assistance provider's interpretation and translation services.
    - Collaborative efforts including attending clinical staff meetings to address any concerns relating to language assistance access.
    - Expanding VCBH language assistance provider network.
    - Participation in the Quality Improvement Staff Experience and Quality Oversight sub-committees.
    - Submission of VCBH's FY23-24 Cultural Competency Plan to DHCS.
    - Onboarded a Program Administrator for the Office of Health Equity.

4. Summary of Results and Next Steps
    - Working on recruitment for an additional team member for the Office of Health Equity.
    - Working on updating the Cultural Competency Plan for FY24-25.
    - Revising existing policies and procedures relating to cultural competency.
    - Updating cultural competency training for community-based organizations (CBOs).

- VCBH will work on meeting the goal of at least 85% of existing staff completing their annual cultural competency training as assessed by attestations and training completions from VCBH's learning management system.

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5. Plan for Current Goal

☐ Keep the goal with no change for the upcoming year

☒ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments: Objectives will be modified according to department needs (see QAPI FY24-25 Workplan)

☐ Completed - retiring the goal

Initiative 4. Optimal Beneficiary Outcomes

Goal # 4.1 – Grievances & Problem Resolution

1. Objectives:
    a. At least 75% of grievances filed will be resolved within 90 days of receiving them (Baseline FY22-23 = 73%) [for both MH & SUS]
    b. At least 60% of appeals will be resolved within 30 days (Baseline FY22-23 = 51% [for both MH & SUS]
    c. Maintain 100% compliance with QM 18
    d. Regular reporting of grievances will be made to the QIC Quality Subcommittee

2. FY 2023-2024 Overall Goal was: ☒ MET ☐ Partially MET ☐ Not MET
   Notes/Comments:

3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - Collecting grievance and appeal numbers/data from all contracted providers on a monthly basis to ensure timely quarterly reporting to DHCS.
    - Educating Operations, including contracted providers, to ensure that all grievances and appeals are being reported and processed as needed.
    - Updated the Grievance and Appeal operational manual to take into account new electronic health care record and DHCS reporting mandates.
    - Developing a Best Practices Manual that will address grievances and appeals within Operations

4. Data/Results:

Type	# total for FY 23-24	Resolved within timeline (90 days for grievances, 30 days for appeals)	Percentage resolved within timeline
Grievances	109	109	100%
Appeals	5	5	100%

5. Summary of Results and Next Steps for the New Fiscal Year
    - Of the 109 grievances received, 109 were resolved within 90 days.

- Of the 5 appeals received, 5 were resolved within 30 days.
- Continue to work with contracted providers on reporting of all grievances and appeals with a focus on Discrimination grievances.
- Meet and work with QIC committee representatives to ensure reporting of grievances and appeals in a manner that will be informative to the committee and help to inform operational practices.

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6. Plan for Current Goal

☐ Keep the goal with no change for the upcoming year

☒ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments: Objectives will be slightly modified to align with VCBH's performance.

☐ Completed - retiring the goal

Goal # 4.2 – Beneficiary Outcomes

1. Objectives:
    a. Improve response rates to the MH Consumer Perception Survey (CPS) & SUS Treatment Perception Survey (TPS) by 10% from the prior year by restructuring the administration process of the surveys
    b. At least 85% of youth/families of youth in care will indicate they are satisfied with services (agree or strongly agree)
    c. At least 85% of adults/older adults in care will indicate they are satisfied with services
    d. 10% improvement in retention rates within clients in outpatient treatment will be observed

2. FY 2023-2024 Overall Goal was: ☒ MET ☐ Partially MET ☐ Not MET

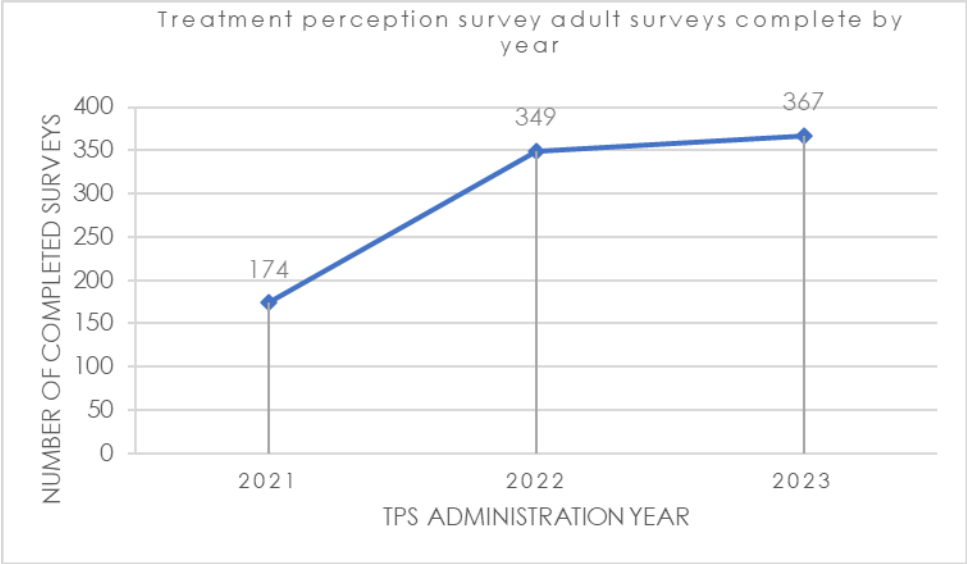
    Notes/Comments:

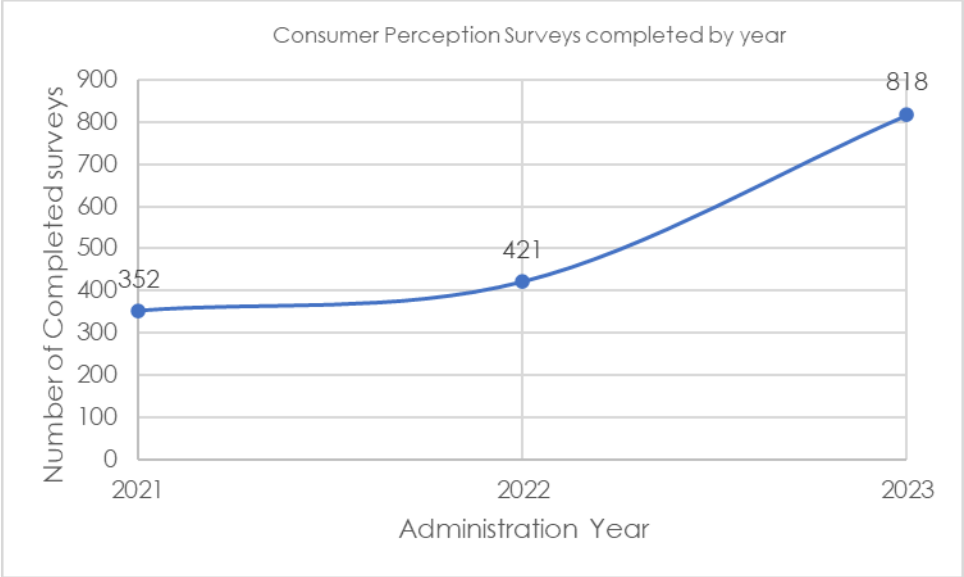
3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - For the Treatment Perception Survey, Quality Improvement staff attended virtual group sessions to disseminate surveys to persons in care that only access services remotely.
    - Quality Improvement learned through the post-administration survey that communication for the surveys should go directly to Office Staff, not just clinic administrators to be filtered down. This change helped increase response rates to both surveys.
    - Response rates for both the CPS and TPS were improved over the prior year's administration (see below)

4. Data/Results:

Satisfaction Item(s)	Youth & Family CPS	Adults CPS	Adult TPS
Overall, I am satisfied with the services I received.	86% Agree	89% Agree	94% Agree





5. Summary of Results and Next Steps
    - Adult TPS was able to increase response rates by 5% while the CPS was able to increase response rates by 95%
    - CPS Youth and Adults, and TPS Adults were all above the 85% satisfaction standard

6. Plan for Current Goal

☒ Keep the goal with no change for the upcoming year

☐ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments: Goal area will be carried over to FY24-25 with slight modifications to the objectives

☐ Completed - retiring the goal

Goal # 4.3 – Monitoring of Medication Management/Education

1. Objectives:
    a. At least 90% of beneficiary questions regarding medications will be addressed within 30 days of inquiry (or their next doctor visit) via informational sheets on medications provided
    b. At least 70% of beneficiaries should have a consent on record with their provider regarding their medications or be provided with informational sheets100% of relevant staff will be trained to ensure pertinent information regarding treatment medications are consistently conveyed to beneficiaries (via Target Solution attestations)

2. FY 2023-2024 Overall Goal was: ☐ MET ☒ Partially MET ☐ Not MET
   Notes/Comments: In practice, 100% of beneficiaries will have any questions/concerns regarding medications addressed during their meetings with their provider. Currently, there is no concrete way to track this. Informational sheets on medications are distributed to beneficiaries at the time of their prescriptions. Regarding Objective b, due to the transition to a new EHR and changes in the methods of consent, there is no way to ensure that beneficiary consent is on record. Staff policies are in place and staff are trained to ensure pertinent information is relayed to beneficiaries regarding their medications

3. Quality Improvement Activities/Actions Taken Over the Past Year:

    - Based on experiences this year and recognition of what is needed to advance this goal, in FY24-25, we will refine our methods of medication monitoring and education and focus on educating staff on required HEDIS performance measures
    - Also, in Q1 of FY24-25 a HEDIS education and awareness campaign is launching to make relevant staff aware of the criteria involved for each of the 9 required HEDIS measures.

4. Plan for Current Goal

☐ Keep the goal with no change for the upcoming year

☒ Keep the goal but slightly revise the objectives to meet the needs for next year

Comments: Objectives were revised to reflect a new direction in medication monitoring and education – see QAPI FY24-25 work plan

☐ Completed - retiring the goal